DECISION
OF AGENCY
ON APPEAL

In the Appeal of: [redacted]

For: Qualified Health Plan

Agency: MNsure Board

Docket: 157813

On December 23, 2014, Appeals Examiner Kulani R. Moti held an evidentiary hearing under 42 United States Code §18081(f), Minnesota Statute §62V.05, subdivision 6(a) and Minnesota Statute § 256.045, subdivision 3.

The following people appeared at the hearing:

[redacted] Appellant;
[redacted] Appellant's Husband/Witness.

Based on the evidence in the record and considering the arguments of the parties, the appeals examiner recommends the following findings of fact, conclusions of law, and order.

STATEMENT OF ISSUES

Whether the MNsure Board correctly determined that the Appellant is ineligible for enrollment in a QHP outside of the open enrollment period because she did not experience a loss of minimum essential coverage.

FINDINGS OF FACT

1. [redacted] (Appellant) completed an online MNsure Exchange (MNsure) health insurance application on August 1, 2014. *Exhibit 1.* On October 24, 2014, MNsure sent written notice to Appellant that she was ineligible for a special enrollment period to enroll in a Qualified Health Plan (QHP) because she had not lost minimal essential coverage. *Exhibit 1.* The Appellant filed a request challenging the denial of a special enrollment period on November 19, 2014. *Exhibit A.* On December 23, 2014, Appeals Examiner Kulani R. Moti held an evidentiary hearing via telephone conference. The judge accepted into evidence two exhibits[1]. The record was held open, by request of Appellant, until January 5, 2015 for additional documents to be submitted. On January 5, 2015, the record was closed with one additional exhibit[2] for a total of three exhibits.

2. In 2013, Appellant had short term medical coverage for her and her family. *Testimony of Appellant.* On July 31, 2014, Appellant and her family's short term medical coverage was not renewed and the policy ended. *Testimony of Appellant.*

3. Appellant applied for health care coverage through the online MNsure Exchange as a family of three. *Exhibit 1.* MNsure determined the household meets the eligibility requirements for a qualified health plan. On August 11, 2014, Appellant enrolled in a qualified health plan for September 1, 2014 coverage. *Exhibit 1.* MNsure sent Appellant's enrollment information to the selected health plan carrier. The health plan carrier requested verification of the loss of minimum essential coverage from Appellant. *Exhibit 1; Testimony of* [redacted] Appellant provided the requested information to the health plan carrier. *Testimony of* [redacted] The health plan carrier determined that there was no loss of minimum essential coverage because Appellant's previous coverage was short term medical insurance. *Exhibit 1.*

4. Appellant had been verbally informed in August 2014 by the MNsure call center that Appellant and her household were approved for a qualified health plan. *Testimony of Appellant.* Appellant relied on that verbal information. In August 2014, Appellant incurred some medical expenses and Appellant had assumed it would be

[1] Ex. A, Appeal Request; Ex. 1, MNsure Appeals Summary.
[2] Ex. B, Appellant's timeline.

covered because they had been informed that they were approved. *Testimony of Appellant.*

5. Appellant is trying to obtain the required insurance and argues that she is unable to. *Testimony of* [redacted] Appellant asserts that the short term medical coverage was legal insurance coverage and is minimum essential coverage. *Testimony of* [redacted] Appellant had obtained short term medical coverage contract in August 2013 for sixth months. In February 2014, Appellant signed another six month contract for short term medical coverage. *Exhibit B.* In July 2014, Appellant was informed by the short term medical insurance company that another sixth month short term medical contract would not be offered to her because of changes in Minnesota law. *Exhibit B.* Appellant knew that the short term medical coverage she previously had was temporary insurance. *Testimonies of Appellant and* [redacted] Appellant chose not to enroll in MNsure during previous open enrollment periods because they had temporary insurance coverage. *Testimony of* [redacted]

6. MNsure asserts that consumers are eligible for a 60-day special enrollment period if they have a qualifying event, such as loss of minimum essential coverage, but appellant's short-term health insurance policy does not meet the definition of minimum essential coverage. *Exhibit 1.*

APPLICABLE LAW

7. For MNsure appeals, an appeal must be received within 90 days from the date of the notice of eligibility determination. *45 C.F.R. § 155.520(b)(1); Minn. R. 7700.0105, subp. 2(D).*

8. The MNsure Board has the legal authority to review and decide issues in this appeal regarding Appellant's eligibility through MNsure for Advance Premium Tax Credits, Cost Sharing Reductions, Qualified Health Plan, and/or the Small Business Health Insurance Options Program. *Minn. Stat. § 62V.05, subd. 6.* The MNsure Board has an agreement with the Department of Human Services to hear and decide appeals involving premium assistance. The Commissioner of the Minnesota Department of Human Services has the legal authority to review and decide issues in this appeal regarding Appellant's eligibility for Medical Assistance and MinnesotaCare. *Minn. Stat. § 256.045, subd. 3.*

9. Minn. R. 7700.0105, subp. 1(A) provides that MNsure appeals are available for the following actions:

> (1) initial determinations and redeterminations made by MNsure of individual eligibility to purchase a qualified health plan through MNsure;
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> (2) initial determinations and redeterminations made by MNsure of eligibility for and level of advance payment of premium tax credit, and eligibility for and

level of cost sharing reductions;

(3) initial determinations and redeterminations made by MNsure of employer eligibility to purchase coverage for qualified employees through the Small Business Health Options Program;

(4) initial determinations and redeterminations made by MNsure of employee eligibility to purchase coverage through the Small Business Health Options Program;

(5) initial determinations and redeterminations made by MNsure of individual eligibility for an exemption from the individual responsibility requirement;

(6) a failure by MNsure to provide timely notice of an eligibility determination;

(7) in response to a notice from MNsure under Code of Federal Regulations, title 45, section 155.310 (h), a determination by MNsure that an employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide coverage but is not affordable coverage with respect to an employee; and

(8) in response to a denial of a request to vacate a dismissal.

10. Pursuant to 45 C.F.R. § 155.410(a)(2) the Exchange may only permit a qualified individual to enroll in a QHP or an enrollee to change QHPs during the initial open enrollment period, the annual open enrollment period, or a special enrollment period for which the qualified individual has been determined eligible. The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014. *45 C.F.R. § 155.410(a)(2) (b).* For the benefit year beginning on January 1, 2015, the annual open enrollment period begins on November 15, 2014, and extends through February 15, 2015. *45 C.F.R. § 155.410(a)(2)(e).* The Exchange must allow a qualified individual or enrollee to enroll in or change from one QHP to another if:

1) the qualified individual or his or her dependent loses minimum essential coverage;

2) the qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care;

3) the qualified individual, or his or her dependent, which was not previously a citizen, national, or lawfully present individual gains such status;

4) the qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange;

5) the enrollee or, his or her dependent adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

6) the enrollee is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions;

7) the qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move;
8) the qualified individual is an Indian;
9) the qualified individual or enrollee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide;[3] or
10) it has been determined by the Exchange that a qualified individual or enrollee, or his or her dependents, was not enrolled in QHP coverage; was not enrolled in the QHP selected by the qualified individual or enrollee; or is eligible for but is not receiving advance payments of the premium tax credit or cost-sharing reductions as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. *45 C.F.R. § 155.420(d).*

11. Minimum essential coverage is defined in 26 U.S.C. § 5000A(f)(1) as coverage which is: 1) government sponsored; 2) employer sponsored; 3) a health plan offered in the individual market within a State; 4) a grandfathered health plan; or 5) other health benefits coverage.

12. The Administrative Simplification provisions of the Affordable Care Act of 2010 (ACA) expand upon the Health Insurance Portability and Accountability Act of 1996 (HIPAA) by including requirements for operating rules for each of the HIPAA transactions, enumerations of a unique, standard Health Plan identifier, new standards for electronic funds transfer and electronic health care claims attachments, health plans to certify compliance with the standards an operating rules, penalties for health plans that fail to comply or certify their compliance with applicable standards and operating rules. *Administrative Simplification Provisions in the Patient Protection and Affordable Care Act of 2010 (ACA)(Public Law 111-148) §1104.*

[3] Pursuant to HHS Centers for Medicare & Medicaid Services (CMS) Guidance dated May 2, 2014 ("Special Enrollment Periods and Hardship Exemptions for Persons Meeting Certain Criteria") hardship exemptions were granted for persons who obtained coverage that was effective May 1, 2014. Special enrollment periods were authorized for individuals eligible for or enrolled in COBRA and for individuals whose individual market plans are renewing outside of open enrollment. Special enrollment periods and hardships exemptions were authorized for AmeriCorps/VISTA/National Civilian Community Corps members. See:
http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/SEP-and-hardship-FAQ-5-1-2014.pdf
CMS Guidance dated March 24, 2014, authorizes special enrollment period consideration for consumers facing exceptional circumstances such as a natural disaster, medical emergency or a planned system outage which occurs on or around plan selection deadlines and for misrepresentation, misinformation, errors or inaction on the part of the Exchange, Navigators, or QHPs. See:
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/complex-cases-SEP-3-26-2014.pdf

13. Under HIPPA "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance. *42 U.S.C. § 300 gg-91(b)(5).*

14. Under the ACA, health plans that meet the minimum essential coverage standard must cover ten "essential health benefits" (ambulatory patient services; emergency services; hospitalization; pregnancy, maternity, and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services, and chronic disease management; and pediatric services) and cover at least 60% of allowed medical expenses. *45 C.F.R.§ 156.110.*

15. Under the ACA, health insurance plans must have fair health insurance premiums, guaranteed availability of coverage, guaranteed renewability of coverage, prohibit pre-existing condition exclusions or other discrimination based on health status, prohibit discrimination against individual participants and beneficiaries based on health status, ensure non-discrimination in health care, provide comprehensive health insurance coverage, prohibit excessive waiting periods, and provide coverage of individuals in approved clinical trials. *Amendments to the Public Health Service Act in the Patient Protection and Affordable Care Act of 2010 (ACA)(Public Law 111-148) §1101.*

CONCLUSIONS OF LAW

16. This appeal is timely under 45 C.F.R §155.520(b) and Minn. R. 7700.0105, subp. 2(D).

17. Pursuant to 45 C.F.R. § 155.420(d) set forth above, MNsure must allow the Appellant to enroll in a QHP outside the open enrollment period if she loses minimum essential coverage. The Appellant contends that she lost minimum essential coverage effective July 31, 2014, when her short-term insurance policy terminated.

18. However, under the HIPAA provisions, short-term insurance policies are excluded from the definition of allowable individual health insurance coverage. Because the short-term policies are not compliant with the Administrative Simplification Provisions in the Patient Protection and Affordable Care Act of 2010 (ACA)(Public Law 111-148) §1104, those policies are not considered to provide minimum essential coverage under the ACA.

19. For the foregoing reasons, I find that Appellant has not lost minimum essential coverage because her short-term policy is not viewed to be allowable individual health insurance coverage under HIPAA and compliant with the Administrative

Simplification Provisions in the Patient Protection and Affordable Care Act of 2010 (ACA)(Public Law 111-148) §1104. There is no evidence in the record that appellant meets any other special enrollment period criteria set forth in 45 C.F.R. § 155.420 or in the CMS Guidance, cited above. Accordingly, MNsure correctly determined that the Appellant was not eligible for a special enrollment period in a qualified health plan.

RECOMMENDED ORDER

THE APPEALS EXAMINER RECOMMENDS THAT:

- The MNsure Board AFFIRM the determination that the Appellant is ineligible for enrollment in a QHP outside the open enrollment period effective August 11, 2014.

/s/Kulani R. Moti
Kulani R. Moti
Appeals Examiner

March 2, 2015
Date

ORDER

IT IS THEREFORE ORDERED THAT based upon all the evidence and proceedings, the MNsure Board adopt the Appeals Examiner's findings of fact, conclusions of law and order as each agency's final decision.

FOR THE MNSURE BOARD as to any effect the decision has on Appellant's eligibility through MNsure for Advance Premium Tax Credits, Cost Sharing Reductions, Qualified Health Plan, and/or the Small Business Health Insurance Options Program.

_____ _____
Date

cc: [redacted] Appellant
[redacted] MNsure

FURTHER APPEAL RIGHTS

This decision is final, unless you take further action.

Appellants who disagree with this decision should consider seeking legal counsel to identify further legal recourse.
If you disagree with the effect this decision has on your eligibility for **Advance Premium Tax Credits, Cost Sharing Reductions, Qualified Health Plan, and/or the Small Business Health Insurance Options Program**, you may:

- **Appeal to the United States Department of Health and Human Services (DHHS)** under 42 U.S.C. § 18081(f) and 45 C.F.R. § 155.520(c). This decision is the final decision of MNsure, unless an appeal is made to DHHS. An appeal request may be made to DHHS ***within 30 days of the date of this decision*** by calling the Marketplace Call Center at 1-800-318-2596 (TTY 855-889-4325); or by downloading the appeals form for Minnesota from the appeals landing page on www.healthcare.gov.

If you disagree with this effect this decision has on your eligibility for **Medical Assistance and/or MinnesotaCare** benefits, you may:

- **Request the Appeals Office reconsider this decision.** The request must state the reasons why you believe your appeal should be reconsidered. The request may include legal arguments and may include proposed additional evidence supporting the request; however, if you submit additional evidence, you must explain why it was not provided at the time of the hearing. The request must be ***in writing***, be made ***within 30 days of the date of this decision,*** and a ***copy of the request must be sent to the other parties***. Send your written request, with your docket number listed, to:

  Appeals Office
  Minnesota Department of Human Services
  P.O. Box 64941
  St. Paul, MN 55164-0941
  Fax: (651) 431-7523

- **Start an appeal in the district court.** This is a separate legal proceeding, and you must start this ***within 30 days of the date of this decision*** by serving a notice of appeal upon the other parties and the Commissioner. The law that describes this process is Minnesota Statute § 256.045, subdivision 7.